Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Places to Flourish

A pattern-based approach to foster change in residential care

The Dining Experience

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Introduction

> *. . . A good dining experience involves not just the food, but also its presentation and the environment in which it is served*

Ruigrok and Sheridan 2006:420

The dining experience is an opportunity for residents to practice the independence they once knew and daily living skills they still desire. With due consideration for the dietary requirements of residents, meal ambiance, and the coordination of the care team, these desires can be reached. Residents benefit from a positive dining experience, while care staff gain more insight into the individual needs of residents. In this section we explore patterns associated with the dining experience and its impact on the clinical care and quality of life of residents.

The Dining Experience: A Typical Example

Rose House, a Georgian building that is over 150 years old, is a large three storey building with a basement and has been converted and modified over the years for use as a nursing home. The building benefits from an abundance of natural light, muted tones and light wood and is set in spacious grounds with large garden areas. Care is provided for a total of 31 long-stay residents, with three places allocated for respite beds. Accommodation for residents is provided in single and multi-occupancy rooms. Men are accommodated on the ground floor in two five-bedded rooms and a single room. Women live on the first floor in two multi-occupancy rooms ranging in size from three to six beds, and a single room. There is also an area known as 'the unit' that contains two multiple occupancy rooms housing ten residents alongside an additional five single rooms.

The unit has been the focus of 'culture change' efforts towards a more homelike environment based on the 'household model'; the unit contains its own kitchen, sitting/dining room, and a quiet area. Residents and staff/relatives use the kitchen to make tea and for cooking and baking. The area is bright and spacious and opens onto an enclosed garden. The unit has a dedicated staff, including a homemaker, working almost exclusively in the unit in order to foster meaningful relationships between residents, staff, and residents' families. Cross-training of staff means persons in existing occupations or grades acquire additional skills or an extended roles in housekeeping, nursing, food service and activities) to support a variety of resident needs. Cross-training also makes the facility less hierarchical and empowers individual team members ensuring everyone has the ability and opportunity to directly care for residents in a diverse and meaningful way. For example, in the household model, it is not uncommon for a clinical nurse manager to prepare an evening snack, or for health care assistant to be actively involved in a group or individual activity.

It is 8am in the morning; the more mobile residents [Maureen, Kathleen and Margaret] make their way down to the kitchen for breakfast. The kitchen is warm, bright and inviting. An oil-burning stove gives the room a welcoming feel. The large windows provide good views of the garden and of the raised beds where residents grow flowers and herbs for the kitchen. The kitchen units, fridge and cooker fill one comer of the room, enabling household staff to prepare breakfast for everyone. Boiled eggs, porridge and toast are all cooked by household staff in the kitchen.

Maureen is looking forward to going out for the day and is busy chatting to a nurse while at the same time looking at the breakfast menu; she decides to have a bowl of porridge and a cup of tea. Prior to coming to live in the home, Maureen enjoyed going to town once a week and the staff in Rose House have supported her to continue to do so. Maureen likes to finish her day out with a small whiskey before returning to Rose House for supper. The staff know that she can become argumentative and uncooperative should something delay or disrupt her plans. They also know that some less mobile residents, such as Brigid, need assistance to use the bathroom at this time. Brigid is confined to a wheelchair but is a very active member of the home, enjoying painting, gardening, reading and discussing politics with Ann who lives in the room next to her.

When she wakes up Brigid likes to…

1. Go to the bathroom.
2. Wash her face and comb her hair before having breakfast.
3. Have two cups of tea, a slice of toast and, sometimes she also likes a soft-boiled egg. She usually alternates between toast, eggs and porridge.
4. Take her medication with her breakfast
5. Check her 'smalls' are warming on the radiator and that the dog has not run off with them!
6. Take the dog's food from the fridge so that it is not too cold.
7. Check that the dog has been let out for a run so that he does not have 'an accident' in the house.

Brigid wakes up at 7.30am. She is not able to get into her wheelchair, go to the bathroom or to dress without assistance. Brigid likes to wash her face and comb her hair before she has her breakfast. She always has breakfast in bed. She is a very chatty person and when the health care assistant comes to take her to the toilet she likes to talk about how well, or not, she slept the night before and about what sort of a night the little dog had and if he slept in his basket or at the foot of Brigid's bed. This pleasant exchange of conversation is an important start to the day for Brigid.

But Think . . .

The Challenges: at the same time as Brigid wants to go to the toilet and Maureen wants to have her breakfast as quickly as possible so that she can go to town, there are at least four or five others who want to go to the toilet and one or two who are 'light sleepers' and like to doze to about 9.30 or 10am before they have their breakfast. Staff try to be as quiet as possible so as not to disturb the 'light sleepers'; Sheila, Mary and Patricia, otherwise they will be drowsy all morning and may miss out on their favourite activities. Sheila, Mary and Patricia, have been instrumental in establishing the herb garden which provides a regular supply of herbs to the kitchen. At the same time, several members of staff are busy helping out with breakfast, one staff member is busy preparing cups of 'thickened water' for residents who are losing their ability to swallow, and a nurse is busy preparing medications for those residents who prefer to take their medicines with their breakfast. It is the start of the day and the residents who are awake are anxious to have their care needs attended to so that they can get on with their day.

Meeting the challenges of a positive dining experience means residents have choices (about what to eat, when to eat, where to eat, whom to eat with, how leisurely to eat), that they enjoy appropriate meal ambiance, and are supported by responsive and sensitive staff. Positive dining experiences are fostered when staff and residents work collaboratively within meaningful relationships based on trust and mutual respect and when the design features of the environment are conducive to a positive experience.

The social significance of mealtimes….

"Mealtimes are about much more than just food; they are social events. It matters where we eat, where we sit and who we sit with; I just love sitting with my friends."

The Dining Experience: Patterns of Activity

From infancy, food and dining experiences are at the core of a rich set of fundamental sensory and emotional memories about our world (Ronch, 2009). Many of our favourite memories and experiences—preparing and sharing a meal with family members, celebrating birthdays, anniversaries and other life events with a special meal, and getting together with friends for dinner—all involve food and dining experiences. Such dining experiences may be well entrenched in an individual's daily routine. So forcing changes to this routine may be emotionally and functionally disruptive. Thinking back on your life, how many memorable occasions involved a meal?

Residents of long-term care facilities miss their own homes and the control over their own diets and the dining ambiance to which they were accustomed. They wish for attractive meal service and the food rituals and traditions associated with family meals and social occasions (Evans et al., 2004). Their quality of life is linked to meal time experiences and social interactions; having food that supports nutritional health and well-being while taking account of individual food preferences, lifelong eating habits and cultural traditions (Rosenzweig, 2003, cited in Ruigrok, & Sheridan, 2006).

As we age, it is natural that we eat less because we are less physically active. However, because older adults need fewer calories, they are at risk of developing a deficiency in essential minerals or vitamins unless there is a corresponding increase in the quality of the food they consume (Miller, 2009). A poor diet may also lead to muscle wasting and bone loss and a weakened

immune system. So mealtimes are also central to the nutritional care of residents in long-term care facilities. To make the most of dinning opportunities, dining experiences for residents necessitate individualized care that reflects interdisciplinary, multi-level interventions (Gibbs-Ward & Keller, 2005, cited in Aldridge, 2007).

Non physiological factors, such as the number of other people present at meals, the palatability of meals, and the time of day and location of meals, can all play an important role in food intake and the dining experiences of residents. It is important that resident preferences are recognised and the dining experience is made as pleasant and as home-like as possible.

Reflective Activity

Think about your dining patterns and the way you like to eat; the foods you like and dislike, the portions you like, the people you like to eat with, where and when you like to eat, how leisurely you like to eat, what ambiance do you prefer – e.g. lighting, visual stimulation, background music (or silence), furniture? Creating of an environment conducive to eating necessitates asking people what they like, what they are used to, and how did they do it at home?

There are a variety of factors that can impact on food intake and the dining experience of older people. These factors can be internal (to the person) or external (environmental), including:

- **Physical** e.g. vision impairment, chewing or swallowing problems, tremors etc.
- **Sensory** decreased sense of taste and/or smell
- **Cognitive** e.g. difficulty concentrating or paying attention
- **Linked** to the food or menu e.g. unappealing food presentation
- **Psychosocial** e.g. depression, anxiety
- **Environmental** e.g. extraneous noise, size of room, poor visual stimulation, poor lighting, glare, unpleasant odours, and uncomfortable room temperature. Environmental factors also include how appetising meals are e.g. in amount, colour, freshness, taste and smell, how attractively food is arranged on the plate, and appropriate drinks to accompany the food as well as the amount of time people have to eat
- **Health Related** e.g. chronic diseases that decrease appetite, such as diabetes, or food-medication interactions

The Social Significance of Mealtimes . . .

"As I got older, my appetite and my whole approach to food changed. I used to have a great appetite and had no problem eating three meals a day. Now I struggle with to finish one . . . food just doesn't taste and smell the same as it used to . . . I just don't have the same interest in food that I used to have"

As we age, it is common for our appetite to get smaller. Often, we are less physically active in our later years, so our energy requirements are less. Also, as we age our bodies lose some muscle and burn fewer calories. However, if an older person's appetite has diminished, it is still important that they get all the energy and nutrients that their body needs. Older people who have a poor diet are at increased risk of malnutrition. Malnutrition adversely affects well-being and quality of life; it is related to increased apathy and depression, weakness and fatigue (Corish, 2006). Research by University College Dublin) estimates that 70,000 people aged 65 and over may be either malnourished or at significant risk of malnourishment in Ireland, thought to affect over 10% of people over the age of 65 (UCD 2010).

There are a number of ways in which the nutritional status of older people can be improved, including food fortification, nutritional supplements, offering small portion sizes, food presentation e.g. adding a sprig of parsley, rosemary, tarragon or thyme can make the difference between a boring plate of food and an edible, appetising main course. Fruit also makes an attractive garnish for desserts; some of the most beautiful garnishes for desserts are edible flowers!

Other aspects of care that can help the dining experience of people in long-term care include observing, offering encouragement and support, putting the person in a suitable sitting position, ensuring the mealtime environment is appropriate. Paying attention to the environment is central to a positive dining experience. Lawton's (1982) Person-Environment Fit Theory (P-E Fit) holds that environmental factors (e.g. staff behaviors/ attitudes such as lack of sensitivity to individual food preferences, regimented mealtimes, lack of staff, food service policies, excessive noise, lighting, colours etc) impact less on competent people and that the lower the person's competence, the more likely his or her behaviour will be influenced by environmental factors. This suggests that the most frail older people with compromised competence or abilities (e.g. difficulty swallowing, or inability to eat independently) require more supportive environments (Bronwynee, 2004), but it may also mean that over-supportive environments exert too few demands on the person, resulting in apathy, submissiveness and boredom (Redfern, 1999).

So when thinking about how to create a positive dining experience for all residents you should think about the following issues:

Quality of Place and the Physical Environment

The environment is a critical part of a positive dining experience, shaped by a range of factors such as the acoustics, the lighting, the furniture, the food, staff attitudes etc. Think about the impact of these on residents and staff.

Long-term care environments can be noisy places filled with sounds from voices as well as mechanical noises, such as cleaning equipment; and people doing things, such as serving food, setting tables, pushing trolleys. Poor acoustic conditions can have a negative impact of residents' quality of life e.g. excessive background noise can increase resident agitation and stress (O'Keeffe, 2004).

Some noise problems are easier to address than others. For example, carpet can help absorb noise but dining rooms seldom are carpeted. It is necessary to look for alternative solutions e.g. in the in the Georgian building discussed above, curtain were used to absorb noise that bounced of the large bay windows. The folds of the fabric around the bay window help absorb. This is supported by fabric covered acoustic panels which hang several feet for the high ceiling, helping to absorb noise and keep it from reverberating around the room. Where ceilings are of an average height, acoustic panels can hang from the walls. They can be given an old-fashioned, elegant paneled effect if they are framed with a little wood trim (Calkins, & Brush, 2002).

Lighting / Visual Environment

Lighting is another issue which needs careful consideration to ensure a positive dining environment. Older people require three times the amount of light than younger people (Calkins, & Brush, 2002). Therefore a dining room that is well lit may seem overly bright to younger members of the care team, but corners of the room are often not as well lit as the center of the room. Try adding lights and directing the light so it bounces off the walls and does not create glare for residents with visual or cognitive problems.

In the earlier reflective activity, did you identify particular issues associated with light, heat, cold and/or sound that effect how you enjoy a meal? Do you know how these factors affect the residents' in your care?

Choice and Control

Expressing the self through patterns of daily activities is linked to the issue of choice and control.

Think about the residents in the setting where you work. Do you know their food preferences? How much choice and control does the resident have over the personal day-to-day decisions which affect their meals and dining experiences: what they eat, when they eat, where they eat and with whom they eat? Have you asked residents how did they do it at home? Are records of the food and eating preferences of each person kept?

Are you aware of the nutritional requirements and dietary guidelines to assist health professionals and those caring for older people, see 'Recommendations for a national food and nutrition policy for older people' by the Food Safety Authority of Ireland available at
www.fsai.ie/WorkArea/DownloadAsset.aspx?id=1428

Autonomy and Independence

Is there an emphasis on enabling residents to be as independent as they can be, for example, access to aids and equipment to enhance independence – adapted cutlery, plates, cups, plateguards, non-slip mats, table height? Have all care staff, including catering staff, received training on the use of visual aids such as pictorial menus that could facilitate choice for residents with communication difficulties. Are records on dietary needs and preferences of residents and any assistance they may need at mealtimes updated regularly to inform all care staff? Are residents' families aware that you regularly update food records and that you would welcome information on residents' favourite foods and recipes from people who know them well?

Meals are a ritual with stable patterns generally followed on a day-to-day basis. Can you identify the dining patterns of the resident in the facility where you work? As noted earlier, special occasions, such as birthdays and anniversaries often revolve around meals as a centerpiece to the celebration.

The where, when, what, and with whom we eat may also be accompanied by other established patterns such as a read through a favourite newspaper or by listening to a favourite radio programme. Patterns can be entrenched in an individual's daily routine but varying greatly from person-to-person. Any changes to this routine can be both emotionally and functionally disruptive.

Think about your residents, and enquire about their preferences. Find creative ways to help them continue to find meals more than just about eating food. How can you plan meals in a way that works best for all residents and staff? For example, celebrate special events with meals cooked in the kitchen, using residents' recipes. This can help personalise the care for the resident and foster cooperation and a sense of home/family.

Consider how you plan for each meal and the patterns associated with each meal time. Start to plan for these in advance and agree as a team how you will work together to ensure that residents' choices can be met. Discuss with residents how these choices will be met and any issues that might prevent choice being fully met and what compromises are needed.

Consider ways in which the independence of residents can be maximised. For example, Brigid likes growing plants and aromatic herbs for add to flavour food. Although she is confined to a wheelchair she is very capable. Staff created a raised flower bed in the garden where she can plant seeds and tend to them.

For Brigid, this activity helps foster a sense of identify; she plays an important role in the home, providing fresh herbs for the kitchen and fresh flowers for the dining room.

Connection to nature has multiple human benefits which can be gained. Walking and gardening provide the benefits of physical exercise, fresh air, sunshine and social interaction. Being outside may also help to stimulate appetite by providing exercise and fresh air. Studies have also investigated passive interactions of connection to nature, such as viewing a garden. Simply viewing a landscape has been found to produce positive health and well-being in older women, with lowered blood pressure and heart rate the main outcome (Tang & Brown, 2005).

Privacy and Dignity

While some older people may prefer to eat alone, for others the thought of eating meals alone makes it seem more like an obligation than a pleasurable activity, and can result in a lack of interest in food and meal times.

Have you noticed a change in the appetite of any residents in your care? For example whether a person is eating or drinking more or less than usual or visible signs, for example loose clothing which can be a sign of weight loss.

Potential solutions could be as simple as ensuring that dining companions are compatible or that the food is presented in a more appetizing way. Many older people have small appetites, therefore it is important not to present residents with too much food at a time, but to provide frequent opportunities for eating. The point is not to make assumptions about people's preferences – people should be asked what their preferences are. The language you use can also be an important factor in dignity of care and can impact on the individual resident's sense of self and well-being e.g. people eat, they do not 'feed' and adults use napkins or serviettes not 'bibs' so words like 'feeding' and 'bids' should never be used.

Food and meal times play an important part in our social life, holding sensory and emotional memories of special celebratory events with family and friends. For an older person moving to a nursing home forces changes to entrenched patterns which can be not only emotionally but also functionally disruptive. Having options is important e.g. the option of privacy or sharing ones dining space. Accommodating different patterns associated with food and meal times through the provision of options which personalize dining in different ways helps to foster homelike environments. Building on special occasions to celebrate a resident's anniversary or birthday can help encourage eating, release memories, and stimulate conversation among older people.

Consider how you can help residents' to experience positive memories linked to food? Think about the atmosphere in the dining room, the presentation of meals, the way the food looks on the plate, the attitude of the staff. Consider how these factors can influence whether or not the food gets eaten.

Suggested Areas for Place and Practice Improvement

In considering the dining patterns discussed above, you may have identified some aspects which would benefit from changes. To promote and facilitate positive dining experiences, you may want to consider these as potential areas to address. These ideas are in no way exhaustive, but they may provide you with some options for consideration:

- Develop a food preferences record with residents and their families?
- Identify from food preference records residents' food and dining preferences and adjust individual meals to reflect these patterns.
- Set up a meeting with all members of the care team to discuss residents' individual dining preferences and pattern and identify areas of similarity and difference. Consider ways in which you can adjust the way care and practice is organised to take account of these patterns.
- Use Lawton's four dimensions of the environment: the supra personal, personal, social and physical to explore residents' experiences and coping strategies.
- Undertake an observation of a meal time and focus specifically on the social interaction and food intake of residents.
- Undertake an observation of practice activity and focus specifically on how staff engage and support residents during meal times.
- Present your findings from the observations of meal time and identify changes that could be made.

Additional Links and Reading

Royal College of Nursing 'Nutrition Now' is a clinical campaign designed to raise standards of nutrition and hydration in hospitals and the community. It provides practical tools, support and evidence to make to nutrition a priority area for action. See: **www.rcn.org.uk/newsevents/campaigns/nutritionnow/tools_and_resources/older_people**

Publications Associated with the Nutrition Now campaign

RCN Principles for Nutrition and Hydration, plus **Hospital Hydration Best Practice Toolkit** and a series of **factsheets** based on the ten key characteristics for good nutritional care in hospitals.

Enhancing nutritional care booklet, containing a summary of focus sites across the UK. These sites reviewed, implemented and evaluated nutritional care in their clinical setting and it contains their achievements and tips for implementing sustainable changes.

Improving nutritional care workshop designed to be used by anyone working in a team who want to enhance nutritional care. It contains a practical structure for delivering a workshop and ideas to enhance nutritional care and initiate change.

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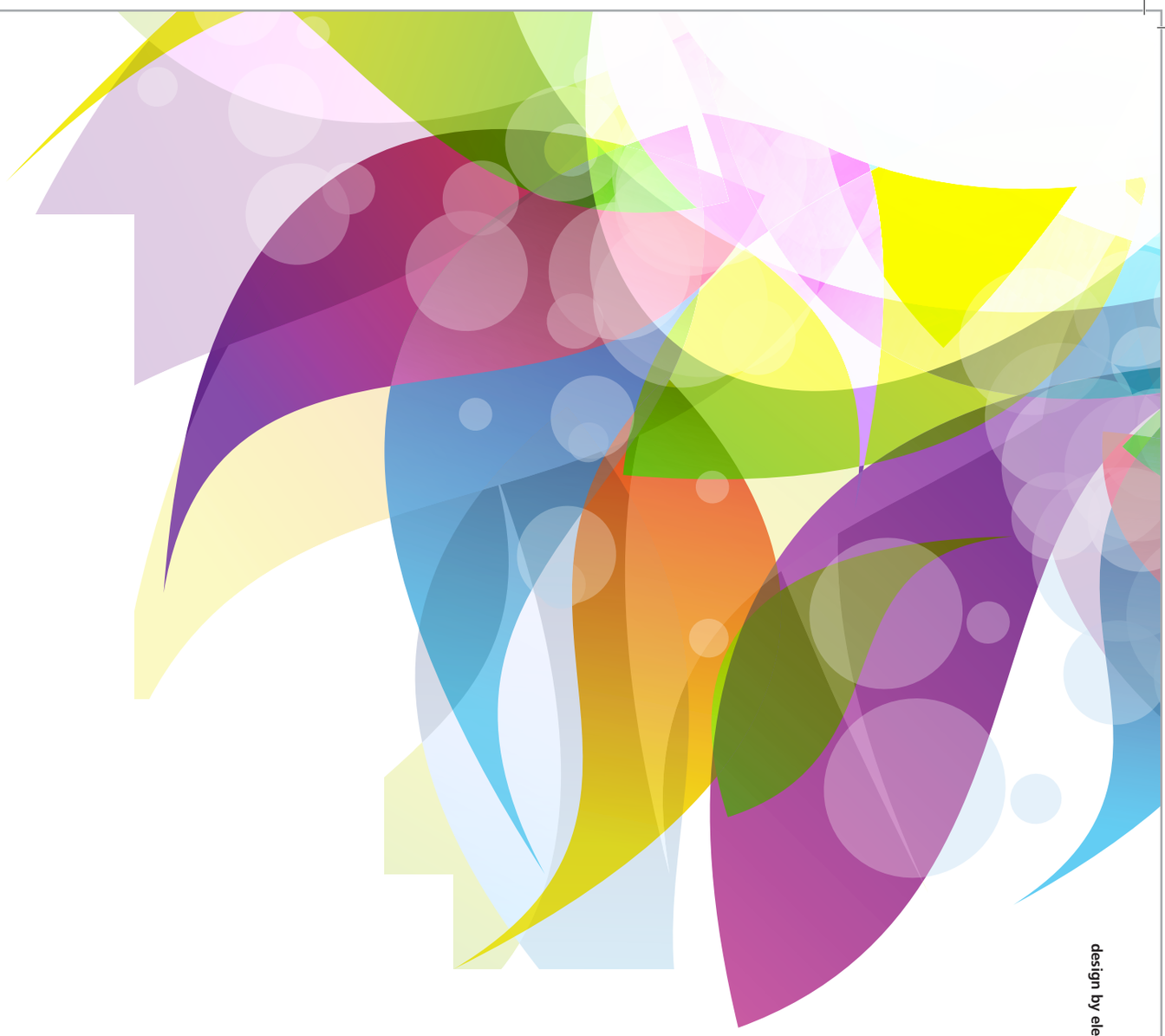

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